Tennessee DENTAL ASSOCIATION

TD CONSORTIUM BENEFITS TRUST

HEALTH PLAN PARTICIPATION
Request/Contract

Effective Date of Coverage:_____

Section 1 Employer Information

Employer Name _____

Federal Tax ID Number _____

Address_____ Phone #_____

City, State, Zip Code_____ Fax #_____

Email Address _____

Participating Association_____ Broker Name_____

Section 2 Billing Information

Billing Address_____ Phone #_____
(if different from above)

City, State, Zip Code_____ Fax #_____

Billing Contact Name _____

Section 3 Billing & Collections Guidelines

Although the contract period is one year (except as provided in Step 7), payment of Health Care Fees will be required monthly. The following guidelines will be used for the Billing and Collection of the Health Care Fee:

1. Around the 15th of each month, you will receive an email from TPA informing you that your new invoice has been posted online for your retrieval.
2. Remittance will be due on the 1st of every month. If payment is not received, or monies are not available for debit from a bank account on the second day of the month health care fees are due, all claims incurred in the delinquent month will be pended or not processed until the account is brought current.
3. Employer also agrees to reimburse the Trust for any claims incurred and/or paid during the delinquent period, including any additional expense incurred due to non-payment.
4. If payment is not received by the 30th day of the month when health care fees are due, your plan will be fully terminated with no opportunity for reinstatement. If payment is received within the 30 days from the original due date, your plan will be reinstated with no break in coverage.
5. If payment is received after the 30 days from the original due date and the account is brought current from the original due date, the group will be considered for coverage but as a new group requiring underwriting.
6. Employee and/or dependent terminations must be sent to the Plan Administrator prior to the termination date. If a termination request is received more than 15 days after the termination date, the employee and/or dependent(s) will not be terminated until the end of the month in which the termination is received, and the employer will be responsible for any applicable Health Care Fees for that month.
7. Billing will be based on the current census of employees in the system as of the date bills are run. Rates may change based on the individual age of each employee at the time of renewal.

By signing this contract, the applicant understands that failure to pay Health Care Fees in accordance with the "Billing and Collection Guidelines" will result in the termination of this contract and that the Group will be responsible for Health Care Fees due and reimbursing the Trust for any incurred and/or paid claims and other expenses incurred during the delinquent period.

Section 4 Effective Date of Coverage

Please note the date that the applicant wishes coverage to start for eligible employees. This date is contingent upon acceptance of this Participation Request/Contract by the Trust. The applicant will be notified of the acceptance of this request and effective date in writing.

Section 5 Plan Type & Employee Coverage

The applicant requests participation for coverage as indicated on the applicants plan selection sheet attached hereto. The applicant requests participation for employees (enter approximate number of employees, including owners, sole proprietors, or partners that are enrolling for coverage).

Section 6 Health Care Fees

Health Care Fee Final Quote (rates) - are effective from the Effective Date of Coverage for up to 12 months (Initial Contract Period). The Plan reserves the right to adjust rates during the contract period should the claim expense plan utilization exceed projections.

Section 7 Contract Terms & Terminations of Contract

Contract Terms: The Plan has four (4) renewal dates: January 1st, April 1st, July 1st, or October 1st, depending on when coverage is first elected. Renewal Rates will be provided at least every 30 days prior to the Renewal Date. Plan Annual Open Enrollment Dates:

For January Renewals:	December 1 - December 31
For April Renewals:	March 1- March 31
For July Renewals:	June 1 - June 30
For October Renewals:	September 1 - September 30

If accepted upon renewal, coverage will be renewed for additional one- year (1) contract periods (Renewal Contract Periods) by payment of the applicable Renewal Health Care Fees due at the Renewal Date. Renewals will be on the same terms and conditions as those in effect for the Initial Contract Period, unless notified otherwise by the Plan.

Termination of Contract: Participating Members may terminate this Contract upon renewal by providing the Plan Administrator written notice within 15 days from the end of the Renewal Contract Period. Participating Members may also terminate this Contract at any time by giving the Plan Administrator written notice at least 30 days in advance of termination date. If written notice is not provided 30 days in advance, the Participating Member will be responsible for Health Care Fees that would be due as if proper notice had been provided, i.e. for the 30 day period.

By signing this contract, the applicant agrees to pay the Health Care Fees as outlined in the attached proposal, as provided in Section 6, based on the census maintained by the Plan Administrator for employees that are eligible for coverage under the benefit plan applied for through the end of the Initial Contract Period, and upon payment of revised Health Care Fees, any Renewal Contract Period. The applicant understands that each Renewal Contract Period will be for additional periods of twelve (12) months and that the Health Care Fees provided by the Trust 30 days prior to the end of each contract period, subject to change as described above.

Section 8 Summary of Benefits and Coverage (SBC)

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to easily compare options and select health plans. Members can access SBC's by visiting the associations website www.tdahealthplan.com. A hard copy of the SBC can also be provided upon request. Please call Aetna at 877-362-0871 for a copy or if you have any questions about the SBC's. For more information regarding this healthcare reform provision, please visit www.healthcare.gov.

Section 9 Underwriting Guidelines

Underwriting Guidelines are enforced from the Effective Date of this contract and remain in effect for each subsequent Renewal Contract Period unless written notification is provided by the Trust.

By signing this contract, the applicant agrees to the attached underwriting guidelines and attached proposal qualifications and understands that should it provide false information or fail to meet the requirements for eligibility, that it will result in either the termination or recession of this contract back to the original effective date for all covered persons.

Section 10 Statement of Contingent Liability

This health coverage is issued by a self-funded qualified multiple employer welfare arrangement. Coverage and benefits provided under a self-funded qualified multiple employer welfare arrangement are NOT protected by the Tennessee Life and Health Insurance Guaranty Association and if the self-funded qualified multiple employer welfare arrangement does not pay expenses that are eligible for payment under the plan for any reason, the employer or employee covered by the plan will be responsible for the payment of those expenses.

Section 11 Participation Request

The applicant requests participation for its employees in the Trust. The applicant also agrees to be bound by all the conditions of participation and further agrees that:

1. Neither this request to participate, nor the payment of any monies to be applied towards the contributions for coverage, shall cause coverage to become effective on any of the applicant's employees. In order for coverage to go into effect on the date specified by this Contract, the applicant must be accepted as a Participating Member and the applicant's employees must satisfy the applicable eligibility requirements.
2. If applicable, the applicant must be a member in good standing with its association when applying for participation in this Trust, must meet membership requirements established by the Bylaws of its associations and must remain a member in good standing with its association for coverage to stay in effect.
3. The applicant has seen a copy of the benefits proposed and agrees to pay the required contributions (Health Care Fees) to the Trust when due and in accordance with the Billing and Collections Guidelines. The applicant further agrees to give all eligible employees an opportunity to enroll for coverage, if contributions from employees are required.
4. The coverage is subject at all times to the benefit plan applied for, which alone constitutes the contract under which benefits become payable.
5. I understand that should my employee(s) intentionally misrepresent a material fact or my failure to report information about my employees may be used as the basis to rescind, terminate, or modify the entire group's coverage or coverage for a particular employee. Rescind means that the coverage was never in effect and as the employer, I will be responsible for any incurred and/or paid claims.
6. I agree that The Plan will not be liable for any health care claims incurred by any Covered Person(s) after the date on which coverage has terminated as it relates to the above Billing & Collections Guidelines. In addition, the employer will reimburse The Benefits Plan for covered charges that are incurred by an employee after the date coverage is terminated.

Acceptance of this request is subject to all of the Trust's requirements including the provisions of any Administrative Services Agreement between the Trust and any third party Administrator, but only to the extent such provisions apply to rights and/or obligations applicable to employers accepted as Participation Employers in the Trust, and terms of the applicable benefit plan. The Trust will notify the applicant of the approval or disapproval of this request. A notice of approval will specify the effective day of the applicant's participation in the Trust. If the applicant is accepted as a Participating Employer, it will receive the appropriate benefit plan descriptions and material for enrolling its employees.

The applicant hereby requests participation in the Trust and agrees to be bound by its terms and conditions and the terms and conditions of the Administrative Services Agreement mentioned in the prior paragraph (to the extent they apply to Participating Employers).

Applicant Print:_____Applicant Signature:_____Date: _____

Section 12 Employer Plan Selection

STEP 1: Select your Medical Plan Option* - You can select one plan or any combination of the ten medical plan options offered based on your eligible employee count. 2-10 employee groups can choose 2 plans, 11-24 employee groups can choose 3 plans, 25-50 employee groups can choose 4 plans, 50+ employee groups can choose 5 plans.

STEP 2: Employee Selection - Send a signed identifying census which plans and what tier (e.g. family, EE, etc.) currently covered employees are choosing. Otherwise, plan implementation cannot move forward and you will experience a delay. "New employees currently not on the plan must fill out an enrollment form."

Note: Please ensure you fully understand the Plan Benefits you are enrolling in, as you can only change your selections during the Plans Open Enrollment. You must email or mail your renewal paperwork.

Medical Plan:

- ☐ Classic 500
- ☐ Classic 1000
- ☐ Classic 2000
- ☐ Classic 3500
- ☐ Classic 5000
- ☐ HSA 5000
- ☐ HSA 6650
- ☐ Value 7350
- ☐ ACO 0
- ☐ ACO 5000

Pharmacy Plan

- ☐ Plan 1
- ☐ Plan 2
- ☐ Plan 3

New Hire Waiting Period

1st of the month following:

- ☐ 0 Days
- ☐ 30 Days
- ☐ 60 Days

☐ Yes ☐ No Apply to Rehires

*Rx Plan 3 is HSA compatible when paired with 5000 HSA or 6650 HSA Medical Plans
*When choosing an ACO option to offer, group must also select non-ACO option

Employer Name _____ Phone # _____

Contact Name _____ Email Address _____

I acknowledge that all my enrolled employees must meet all TDCBT Underwriting Guidelines. I further acknowledge that I must provide waivers for all employees waiving coverage and that I must complete all additional renewal requirements, such as providing Wage and Tax information for employees enrolled. I understand that the elections above override all previous elections and that I am unable to make changes until our next open enrollment.

I take full responsibility that the information I am providing, attached to this Renewal Documentation Form, is accurate and represents all changes/terminations/additions to my enrolled or eligible members for this renewal period. Any requests or discrepancies that arise after the processing of the attached documents may not be eligible for coverage until the next open enrollment period (for changes/additions). Terminations may not be processed until the next eligible termination date, according to the Plan's Underwriting Guidelines, or if I offer coverage through a Selection 125 election, not until the next open enrollment period unless there is a qualifying event.

Applicant Print:_____ Applicant Signature:_____ Date: _____

To be filled out by Plan Administrator

☐ Applicant has been ACCEPTED and has met all participation requirements.
Coverage will become effective as to applicant's eligible employees on:_____

☐ Applicant has been DECLINED and has not met one or all of the participation requirements.

Authorized Representative of the Trust Signature:_____ DATE: _____